

Open Door Forum Newsletter

October 2002

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Hot Announcements !

Town Hall Meeting:

Hospital Restraint and Seclusion Rule

Stats of the Month !

1,792 teleconference lines were open to individual and group participants and more than 180 guests visited with the CMS Administrator and staff during the 12 Open Door Forums held during the month of September.

CMS invites you to our town hall meeting to obtain and discuss general comments concerning the impact of the hospital "1-hour" rule related to the use of restraint and seclusion. Specifically, the meeting, scheduled for Tuesday, October 29, 2002 from 10 am to 1 pm EST, will attempt to solicit individual comments and experiences from providers, advocates, consumers, and other interested parties concerning the application of the "1-hour" rule requiring a physician or a licensed independent practitioner to make a face-to-face assessment within 1 hour of any patient being placed in restraint or seclusion for behavioral reasons.

The opinions and alternatives provided during this meeting will assist us as we evaluate our policy on the "1-hour" rule. Although the deadline has passed to submit requests to participate at CMS' Central Office, you may participate via conference call by dialing **(877) 381-6315** and using **5873460** as your pin number.

Additional Guidance for Applying the Medicare Self-Administered Drug Exclusion

CMS is happy to announce the delivery of PM AB-02-139. This PM, which is designed to provide further guidance, in addition to PM AB-02-072, with respect to determining whether or not an injectable drug, even though furnished incident to a physician's service, is excluded from Medicare payment because it is usually self-administered by the Medicare beneficiaries who use them.

To view this PM in its entirety, please click here:
http://cms.hhs.gov/manuals/pm_trans/AB02139.pdf



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Implementation of National Coverage Determinations Regarding Clinical Diagnostic Laboratory Services

CMS developed a final rule governing coverage of and administrative policies for clinical diagnostic laboratory services under Medicare part B under the Negotiated Rulemaking Act after discussions with a committee of interested parties, including representatives from hospitals, physicians, laboratories, and coding experts.

Although this rule was published in the *Federal Register* (66 FR 58788) on November 23, 2001, we issued Program Memorandum (PM) AB-02-030 (Change Request 1998) on March 5, 2002, to provide instructions for implementing many of the administrative provisions of the rule that became effective February 21, 2002. This PM contains implementing instructions for the 23 National Coverage Determinations (NCDs) that were included as an addendum to the rule and become effective on November 25, 2002.

To view this PM in its entirety, please click here:
http://cms.hhs.gov/manuals/pm_trans/AB02030.pdf

OIG Compliance Program Guidance for Pharmaceutical Manufacturers



A Federal Register notice seeks the comments of interested parties on draft compliance guidance developed by the Office of Inspector General (OIG) for the pharmaceutical industry.

Through this notice, the OIG is setting forth its general views on the value and fundamental principles of compliance programs for pharmaceutical manufacturers and the specific elements that pharmaceutical manufacturers should consider when developing and implementing an effective compliance program.

To assure consideration, comments must be delivered to the address provided in the Federal Register (link below) by no later than 5 p.m. on December 2, 2002. For more details, please click here:

<http://frwebgate5.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=20932716813+1+0+0&WAISaction=retrieve>

FY 04 Hospital Wage Index

CMS has begun the process of collecting wage data for the FY 2004 hospital wage index, which will be calculated using data from cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. By now, all hospitals should have received the wage index development timetable from their intermediaries. Additional information regarding the FY 2004 wage index is available in program memoranda A-02-094 and A-02-095, located at: www.cms.hhs.gov/manuals/memos/comm_date_dsc.asp

The preliminary FY 2004 wage index public use file will be available on the Internet by mid-January, 2003. The deadline for hospitals to request revisions to their published wage data is February 10, 2003. We strongly encourage hospitals to work with their intermediaries early in the process to ensure that the wage data included in the FY 2004 wage index are accurate and complete.

Take A Loved One to the Doctor Day

CMS hosted the *Take a Loved One to the Doctor Day* on September 24, 2002.

The specific aim of this national campaign was aimed in particular at African Americans and racial and ethnic minorities communities, it is designed to greatly stimulate a sense of community awareness of the importance of accessing health care by encouraging individuals and community action across all of America aimed at getting people to take a loved one to the doctor or other health care professional.



Take a Loved One to the Doctor Day is part of a national campaign called "Closing the Health Gap" sponsored by HHS. HHS and ABC Radio Networks entered into a formal agreement to promote the health gap campaign in November of 2001. ABC Radio Networks and many of its 240 affiliates across the U.S. are actively involved in planning and promoting Doctor Day events. Other national sponsors have signed on with ABC Radio Networks to help promote Doctor Day and local events, including Pfizer Pharmaceuticals and Amerigroup Corporation, a multi-state managed health care company.

ABC Radio Networks has been airing 10-second health-related radio spots for the past year focusing on specific minority health issues asking people to become more involved in their health.

There is a serious health gap that exists between African Americans and the general population. African Americans suffer disproportionately from cancer, HIV/AIDS, diabetes, heart disease, stroke and sudden infant death syndrome (SIDS), among other health issues. While a new report from the National Center for Health Statistics recently reported that the life expectancy gap between blacks and whites lessened, the gap is still real, it is still large, and it remains.

There are specific activities that individuals can do to stay healthy and become healthier; taking responsibility for one's own health, and encouraging others to monitor their own health, are key components of a health community.

Pilot to Furnish CY '03 Dear Doctor Material via CD-ROM

CMS recently approved a proposal that was submitted by the Part B carrier, Noridian to furnish the CY 2003 Dear Doctor material to providers via CD-ROM instead of hardcopy. CMS notified Noridian that the proposal was approved as a pilot for the release of the CY 2003 material. Providers in the 11 states that Noridian services will be affected by this pilot.

Providers will receive all related documents for the participation enrollment process on the CD-ROM: the participation announcement, participation agreement, fact sheet and fee schedule payment amounts. The information will be easily downloaded for billing and business analysis purposes. The electronic version of the fee schedule will be easily searched for specific information. The CD-ROM will also contain additional information related to Medicare policies and billing rules.

Several of the significant items that will be provided include: the CMS-1500 Claim form and instructions; HIPAA information; Advanced Beneficiary Notice information and prior years provider bulletins. The Part B carrier has implemented a proactive provider education program to alert their providers about the forthcoming paperless mailing. The Denver Regional Office will closely monitor the results of the pilot and provide ongoing technical assistance to Noridian.

FY '01 Medicare Hospice Utilization Data

CMS is proud to share great news in the recent Medicare hospice utilization trends. Recent Medicare data indicates that more Medicare beneficiaries are electing hospice and remaining on hospice for longer periods of time.

In FY 2001:



- 579,801 Medicare beneficiaries elected to receive the Medicare hospice benefit. This is a 12.8 percent increase from 513,840 individuals electing hospice in FY 2000.
- Medicare spent 3.6 billion dollars for those services. Approximately \$6,228 per hospice beneficiary.
- Home hospice care accounts for almost 90 percent of Medicare hospice expenditures.
- The average length of stay increased from a low point of 44.5 days in FY 1999 to 49.9 days in FY 2001.

To view these and other data, please click here:

<http://www.cms.hhs.gov/providers/hospiceps/default.asp>

The Medicare hospice benefit is a unique Medicare benefit that allows terminally ill individuals to continue life with minimal disruption in activities while remaining at home. Medicare hospice is available to beneficiaries certified by a physician as being terminally ill (with a medical prognosis of six months or less to live if the illness runs its normal course) and elect to receive hospice.

Please click here: <http://www.nhpco.org/public/articles/scully-2.pdf> to review a recent letter from Administrator Tom Scully and articles (<http://www.nhpco.org/public/articles/CMS042002.pdf>) clarifying Medicare coverage rules for the Medicare hospice benefit.

HIPAA Administrative Simplification

Effective October 16, 2003, Medicare will not accept electronic claims in a noncompliant format.

Hopefully, if you are covered entity who transmits or maintains patient data electronically, you were able to meet the deadline to apply for a one-year extension by submitting a compliance plan by October 15, 2002. CMS has been selected by Health and Human Services' Secretary Tommy G. Thompson to enforce the transaction, code set, identifier, and security standards of the Health Insurance Portability and Accountability Act (HIPAA).

The Office of Civil Rights will continue enforcing HIPAA's privacy standards.

Along with continued outreach activities conducted by CMS, enforcement process guidelines and regulations will be developed, which will include how penalties will be imposed for those who either are not compliant or did not file for the extension. The enforcement process will be primarily complaint-driven with a focus on obtaining voluntary compliance through technical assistance.

This exciting initiative, which will dramatically streamline the health care system and shift billions of dollars into actual health care instead of health care administration, is taking the next steps toward enforcement of HIPAA standards.

For the latest on HIPAA, please click here: <http://www.cms.hhs.gov/hipaa/> There, you will also find instructions for signing up for the free list-serve at: <http://aspe.hhs.gov/adminsimp/lisnotify.htm>

Open Door Forum Schedule

To see the most up-to-date ODF Schedule, please click here:
<http://www.cms.hhs.gov/opendoor/schedule.asp>

Newest Disease Management Demonstration

The Physician Group Practice (PGP) Demonstration encourages physician groups to attract, retain and coordinate care to chronically ill beneficiaries; gives physicians incentives to efficiently provide services to their patients; and promotes active use of utilization and clinical data for the purposes of improving efficiency and outcomes.

The PGP Demonstration will enable us to test physician groups' responses to financial incentives for improving care coordination, delivery processes and patient outcomes, and the effect on access, cost, and quality of care to Medicare beneficiaries.

The PGP Demonstration provides a unique reimbursement mechanism through which providers are rewarded for coordinating and managing the overall health care needs of a non-enrolled, fee-for-service patient population. The PGP Demonstration combines new financial incentives with traditional fee-for-service reimbursement that are more in line with those used by managed care organizations and other commercial payers.

Under the 3-year demonstration, physician groups will be paid on a fee-for-service basis and may earn a bonus from savings derived from improvements in patient management. Annual performance targets will be established for each participating physician group equal to the average Part A and Part B expenditures of beneficiaries assigned to the group during a base period, adjusted for health status and expenditure growth.



The solicitation notice and Medicare Waiver Demonstration Application were published in the Federal Register on September 27, 2002. For additional information and materials about the demonstration, be sure to visit:

<http://cms.hhs.gov/healthplans/research>

Once there, select "Physician Group Demonstration."

Hospital Transmittal Number Nine



We recently released Transmittal Number Nine (Chapter 36, Hospital and Hospital Healthcare Complex Cost Report) to reflect further clarification to existing instructions, changes in the CAH outpatient billing, and to implement the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for cost reporting periods beginning on or after January 1, 2002 in accordance with the Benefits Improvement and Protection Act (BIPA) 2000.

Changes detailed in Transmittal Number Nine and access to hospital cost report forms (CMS 2552-96) and instructions can be found here:
http://cms.hhs.gov/manuals/pub152/pub_15_2.asp

At the request of several Rural Health and Hospital Open Door Forum attendees, we made the change in outpatient coinsurance billing for critical access hospitals prospective only.

CMS' Strategic Plan

CMS has been working to update its Strategic Plan, which was last issued in 1998. The Strategic Plan describes CMS' direction for the next several years and changes in the Agency, including the Agency's recent restructuring and new focus on a culture of responsiveness.

In early November, we plan to release the draft Strategic Plan on the CMS Web site at: www.cms.hhs.gov, for a 30-day comment period to obtain feedback from our external partners, stakeholders, and the public on the Agency's future direction. A notice will be posted on the Open Door Forums' Web site when the draft Strategic Plan becomes available for comment. We look forward to using the comments received to strengthen CMS' Strategic Plan.

Split Encounter Billing for E/M services

Section 15501 Evaluation and Management Services Codes, subsection B in the Medicare Carrier's Manual has been revised to address payment for E/M services provided by physicians and non-physician practitioners (NPPs) when an E/M service with a patient is a shared or split encounter between a physician and a non-physician practitioner.

This pertains to a physician and NPP in the same group practice or who are employed by the same employer. The payment policy clarification does not change the current policy as it relates to "incident to" when applicable in the office or clinic setting.

This revised payment policy for Medicare Part B clarifies policy for services that are shared or split in the hospital inpatient, hospital outpatient and emergency department settings. If the physician provides any face-face portion of the split/shared E/M encounter with the patient the service may be billed using either the physician's or the NPP's UPIN/PIN. If the physician discusses/advises the NPP regarding the patient's care but does not have a face-to-face involvement with the patient then the service may only be billed under the NPP's UPIN/PIN.

The section also clarifies how to report an incomplete E/M service (rare circumstance). The previous payment policy in Transmittal #1725 created undue burden on providers and carriers requiring unnecessary manual review of split/shared services.

For further information, the requirements for "incident to" policy can be found in the MCM at 2050.1 and 2050.2. Section 15501 of the E/M Codes, subsection B, will be released on October 23, 2002 and posted to the CMS web a few days thereafter.

Physician Open Door Forum from NC

We're on the road again! This time, to host the Physician Open Door Forum from the University Medical Center at Wake Forest on November 19, 2002. If you are interested in having one or more of our forums hosted from your location, please contact at us at the mailbox below.



Medicare Secondary Payer (MSP) Information Collection Policies

The Policies

On March 22, 2002, the Centers for Medicare & Medicaid Services (CMS) published Program Memorandum (PM) A-02-021 titled, "Medicare Secondary Payer (MSP) Information Collection Policies Changed for Hospitals." The PM applies only to hospital reference lab services and recurring outpatient services in a hospital setting. The policies allow hospitals to bill Medicare using previously collected MSP information that is no older than ninety - 90 - days from the date the service was rendered, for these two services only. Hospital reference lab services and recurring outpatient services in a hospital setting are the only services for which a frequency for updating MSP information has been established.

Background

CMS established the 90-day policies following a request from the American Hospital Association for CMS to reduce hospital burden associated with MSP information collection. Previously, CMS's Hospital Manual admission procedures stated that hospitals must collect this information "upon every inpatient admission, outpatient encounter or start of care." CMS does not plan to establish MSP information collection frequencies for any other providers or any other hospital services. The MSP requirement for all providers is to bill properly. Section 1862(b)(6) of the Social Security Act requires providers to complete the portion of the claim form relating to the availability of other health insurance, based upon information obtained from the individual to whom the item or service is furnished.

To view the PM in its entirety, please click here:
http://cms.hhs.gov/manuals/pm_trans/A02021.pdf

For any information regarding the Open Door Forum Initiative, please feel free to contact Tom Barker, Special Assistant to the Administrator for Policy and Outreach at (202) 690-0056 or: tbarker@cms.hhs.gov

